

# Delivering Mental Health Care in the UK

## Current Issues

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- \* Sociological implications of delivering mental health care in the community

# Background

- \* The National Health Service came into existence on 5 July 1948 with the aim of providing a comprehensive range of health services to all in need.

# UK Mental Health Care before the National Health Service

- \* The County Asylums Act (1808)
  - \* Authorities to build local asylums
  - \* Made mandatory in 1845.
- \* By 1930, ninety-eight asylums accommodating 120,000 patients

# Changes arising from NHS

- \* National Health Service (NHS) introduced in 1948
- \* Took responsibility of funding of Mental Hospitals from local authorities
- \* All Mental Hospitals now funded from central government via the NHS management structures
- \* Small amount of community care available funded locally

# Delivery of care in the NHS

- \* The NHS focussed on centralised mental health care
- \* Allied strongly to the medical model
- \* Patients were admitted into mental hospitals for treatment
- \* In consequence, the medical profession retained power, privilege and controlled the development of services

# Delivery of care in the NHS

- \* Little effective care for long term conditions such as major psychosis
- \* In addition patients became institutionalised
- \* Families lost contact
  - \* Visiting
  - \* Stigma
- \* Patients with major psychosis rarely discharged
- \* Hospitals silted up with “incurable” patients



SPEED  
RETARDER





- 
- ⇐ Conference room
  - ⇐ Toilets
  - ⇐ Ladies hairdressing
  - ⇐ Staff restaurant
  - ⇐ Ballroom
  - ⇐ General office
  - ⇐ Domestic services manager
  - ⇐ Consultant medical staff
  - ⇐ Junior medical staff

- ⇐ Wards
- ⇐ Anderby
- ⇐ Barrowby
- ⇐ Coleby
- ⇐ Digby
- ⇐ Navenby

EXIT

ENQUIRIES













# Beginning of Community Care

- \* 1950s introduction of major anti-psychotic drugs – phenothiazines
  - \* Massive effect on controlling the severe symptoms of major psychosis
- \* Mental Health Act 1959
  - \* community based care
  - \* Increase resources for community based support services
  - \* Day Hospitals/Centres
  - \* Hostels
  - \* Specialist workers
  - \* Local out-patient and hospital access in General hospitals
- \* The 1962 Hospital Plan
  - \* target set to reduce mental illness beds from 3.3 beds per 1,000 pop to 1.8 per 1,000 by 1975
  - \* expansion of local mental health services

# Community Care Benefits to Individual

- \* Fewer admissions to hospital
- \* If admission was needed, this could be done locally
- \* Accessible community services
- \* Reduce stigma

# Community Care Benefit to the State

- \* Great impetus for moving to community based care occurred during the 1980s
- \* Reduce demand on state services resulting in reduced running costs
- \* Resulted in;
  - \* Wholesale move to community care
  - \* Tendering for contracted in services
  - \* Challenging professional roles

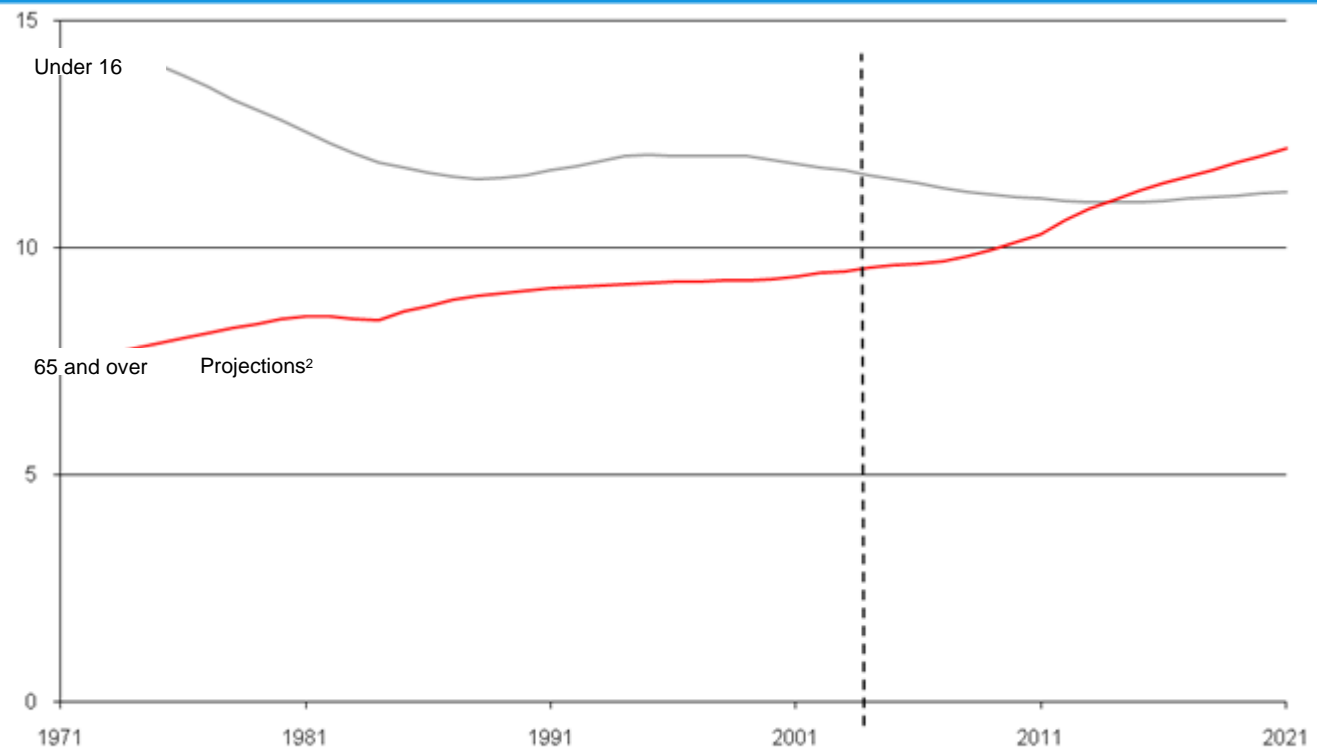


# Community Care Benefit to the State

- \* Most of the old hospitals were closed and the land sold off to local businesses
- \* Between 1979 and 2000 the number of NHS beds in England reduced from 480,000 to 189,000.
- \* Over the same period, independent sector beds rose from 23,000 to 193,000 (Kerrison & Pollock, 2001).

# Demographic context

- \* An ageing population within the UK
- \* Number of wage earners to reduce



**Figure 1.3** Social Trends 34 on-line access March 2010 <http://www.statistics.gov.uk/CCI/nscl.asp?ID=8242>  
**Dependent population<sup>1</sup>: by age**  
 United Kingdom

<sup>1</sup> Population estimates for 2001 and 2002 include provisional results from the Manchester matching exercise.

<sup>2</sup> 2001-based projections.

**Source:** Office for National Statistics; Government Actuary's Department; General Register Office for Scotland; Northern Ireland Statistics and Research Agency

# Current Major Mental Health Services

- \* Acute
- \* Memory assessment
- \* Crisis resolution and home treatment
- \* Improving Access to Psychological Therapies
- \* Child and Adolescent
- \* Early Intervention Services (for psychosis)
- \* Substance Misuse
- \* Recovery
- \* Assertive outreach
- \* Forensic
- \* Prison in reach
- \* Day services

# Community Initiatives for Severely Ill

- \* **The Care Programme Approach**
- \* Someone might get CPA support if they:
  - \* are diagnosed as having a severe mental disorder
  - \* are at risk of suicide, self harm, or harm to others
  - \* tend to neglect themselves and don't take treatment regularly
  - \* are vulnerable. This could be for various reasons, such as physical or emotional abuse, financial difficulties because of their mental illness or cognitive impairment
  - \* have misused drugs or alcohol or have learning disabilities
  - \* rely significantly on the support of a carer, or have their own caring responsibilities
  - \* have recently been detained under the Mental Health Act
  - \* have parenting responsibilities
  - \* have a history of violence or self harm

# Community Initiatives for Severely Ill

- \* **The Care Programme Approach**

- \* Four components:

- \* A systematic assessment of health and social care needs, including a detailed risk assessment, for everyone accepted into specialist mental health services
- \* A care plan which identifies the care required to meet each individuals' needs. This must contain details of who will be involved in providing the care and include risk management, crisis intervention and contingency plans.
- \* A nominated care coordinator who will be available to the patient and who will monitor and evaluate the care provided.
- \* Regular reviews of care with changes to the care plans as appropriate

# Community Initiatives for Severely Ill

- \* **Supervised Community Treatment Orders**
- \* Allow patients who had been detained under section 3, 37, 47 or 48 of the Mental Health Act 1983 (amended by the Mental Health Act 2007) to be treated in the community.
- \* These patients have to comply with a prescribed treatment regime.
- \* If they fail to do so they may be taken forcibly back to hospital for treatment.

# Impact on acute in-patient care

- \* While considerable improvements have been made, both in the provision of care in the community and in encouraging innovative practices, this has often had ramifications on acute in-patient care caused by;
  - \* a reduction in the numbers of in-patient beds,
  - \* more challenging symptoms of the patients who were admitted (because community staff supported less severely ill patients within the community), and;
  - \* an increased number of admissions complicated by drug abuse (Higgins et al, 1999; Watson, 2001).



# Carers

- \* "...the primary sources of support and care for elderly people are informal and voluntary. These spring from the personal ties of kinship, friendship and neighbourhood. They are irreplaceable. It is the role of public authorities to sustain, and, where necessary, develop - but never to displace- such support and care. Care *in* the community must increasingly mean care *by* the community."

(DHSS,1981,Growing Older para 1.9 London, HMSO)

# Legislation to Support Carers

- \* Partnership in Action (1998)
- \* Caring about Carers (1999)
- \* Carers and Disabled Children Act (2000)
- \* Carers (Equal Opportunities) Act 2004
- \* Supporting People with Long Term Conditions: Liberating the talents of nurses who care for people with long term conditions (2005)
- \* Self Care – A Real Choice: Self Care Support – A Practical Option (2005)
- \* Our health, our care, our say: a new direction for community services (2006)
- \* Work and Families Act (2006)
- \* Carers' Allowance
- \* Personal Care at Home Act (2010)

# Sociological implications on delivering mental health care

- \* **Culture**

- \* The significance of mental health problems are framed through the parameters of acceptability within the local society.
- \* Many people in the UK will pray to their God. Some will hear or perceive answers to their prayers through signs.
- \* In Pentecostal Christian churches members of the congregation may shout out unintelligible phrases. This is called speaking in tongues - glossolalia.
- \* In other cultures witch doctors will hear and act on spiritual voices.
- \* It is possible for a mental illness to be diagnosed based on a mis-interpretation of cues that arise from different cultural background of patient and psychiatrist and the local society.

# Sociological implications on delivering mental health care

- \* Interpretation of mental illness between cultures.
  - \* Minority ethnic groups.
  - \* Refugees and asylum seekers.
- \* Local differences between regions.
- \* Social class differences.

# Sociological implications on delivering mental health care

## \* Gender roles

- \* Women's difficulties and demands – employment, homemaker, children – may be oppressive as well as stressful, particularly in single-parent families.
- \* Women may also be caring for elderly relatives, particularly as more care now delivered in community by informal carers.
- \* There are also gender-specific cultural factors.

# Sociological implications on delivering mental health care

- \* **Older people**
- \* In the UK families often move away from each other
- \* Common types of disorder.
  - \* The differences between depression and dementia.
- \* Increasing dependence

# Sociological implications on delivering mental health care

- \* **Social Exclusion**

- \* Social division and association with mental health

- \* Social Exclusion

- \* Involvement of communities

- \* Association between health and wealth and social mobility

